

# *Health Benefits of Good Work*

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**RACGP**

The Royal Australian College of General Practitioners

Healthy Profession.  
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# *Issue 1*

## *GP :*

### *Manager of Health*



# *What is a GP?*

In Australia, the GP:

- Is the first point of contact
- Coordinates the care of patients and refers patients
- Cares for patients:
  - in a whole of person approach
  - of all ages, both sexes, across all disease categories
  - over a period of their lifetime
- Provides advice and education on health care
- Performs legal processes such as:
  - certification of documents
  - provision of reports in relation to motor transport or work accidents

# *At the centre of primary care*

As general practice is largely a relationship-based specialty, GP possess a unique combination of characteristics and skills:

- Person centeredness
- Continuity of care
- Whole person care
- Diagnostic and therapeutic skills

# *Patient management*

- Many patients can be managed in general practice. When needed they are referred to specialists by their GP
- Patients are people not cases or statistics, treat them with respect
- GP should be informed of other stakeholders involvement
- Seeing multiple specialists unnecessarily invariably causes wasted resources
- It is vital to include GP in all communication with other specialists and allied health providers, to avoid duplication
- Tests should be initiated by GP. If not, there are ethical and medico-legal risks.

# GPs across the country

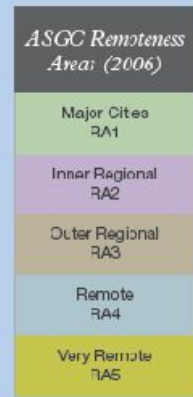
- To date, 34,000 GPs across the country
- 12,000 rural GPs

Table 1. 2013 – 14 National GP workforce figures

	NSW	VIC	QLD	SA	WA	TAS	NT	ACT	NAT
<b>Head Count<sup>(i)</sup></b>	9,969	7,800	6,970	2,554	3,192	855	595	466	32,401
<b>FTE</b>	6,388	4,901	4,031	1,483	1,718	436	159	249	19,365
<b>FWE</b>	7,927	5,828	4,818	1,739	1,953	476	175	277	23,194
<b>Total Services<sup>(iii)</sup> ['000]</b>	47,199	35,297	28,243	10,136	11,898	2,818	971	1,757	138,318
<b>ERP<sup>(iii)</sup> ['000]</b>	7,465	5,791	4,691	1,677	2,551	514	243	384	23,319

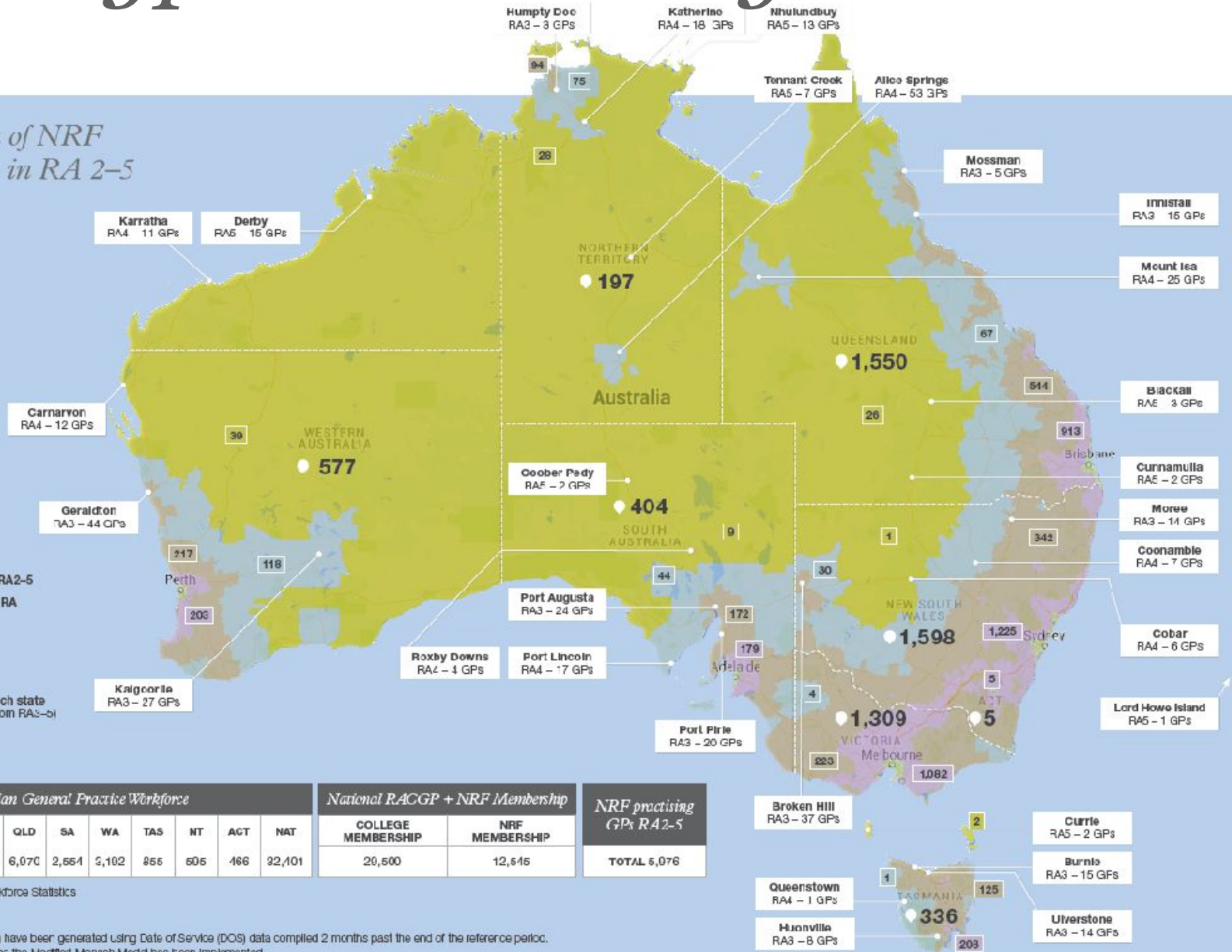
# Rural gps community

National Data of NRF  
practising GPs in RA 2-5



**Key**

- Total NRF Membership in RA2-5
- 00 Total NRF Membership by RA - Practising GPs
- 00 Townships to feature in each state - Practising GPs (p towns from RA3-5)



	Australian General Practice Workforce										National RACGP + NRF Membership		NRF practising GPs RA2-5
	NSW	VIC	QLD	SA	WA	TAS	NT	ACT	NAT	COLLEGE MEMBERSHIP	NRF MEMBERSHIP	TOTAL	
Head Count (1)	0,060	7,300	6,070	2,654	2,102	856	606	466	32,101	20,600	12,646	5,076	

Source: DOH General Practice Workforce Statistics  
Map adapted from DoctorConnect

(1) Headcount figures (revised series) have been generated using Date of Service (DOS) data compiled 2 months past the end of the reference period.  
(2) These figures will be updated once the Modified Monash Model has been implemented.  
Correct as at February 2015

# *Dr -patient relationship*

- Pre-existing relationship – know the patient and their personal circumstances well
- Referral to other specialists or allied providers with understanding of the patient's need, early intervention.
- Act as their manager of health
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# *Issue 2*

## *return to work safely*



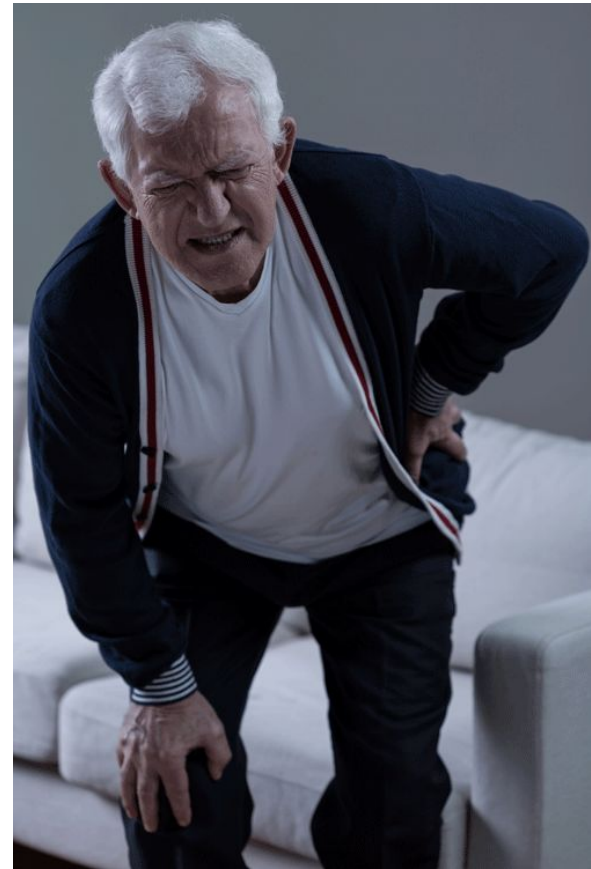
## **.Evidence based key points:**

- \*benefit of work - health and well being
- \*negative impact of long term absence from work,unemployment and disability
- \*impact on family, friends and personal supports
- \*importance of work in recovery

- .Role of GP and physician in helping patients return to work
- .Need to support GPs and other specialists in this role

# *Return to work safely*

- duty of care is for our patients
- HR at work and business owner
- get workers back to work as soon as possible
- special considerations:
  - Chronic pain management
  - GAD general anxiety disorder often due to bullying at work



### At the individual level

For the assessment of individuals: What is the person's level of functioning?

For individual treatment planning: What treatments or interventions can maximise functioning?

For the evaluation of treatment and other interventions: What are the outcomes of the treatment? How useful were the interventions?

For communication among physicians, nurses, physiotherapists, occupational therapists and other health workers, social service workers and community agencies (should a question follow this sentence?)

For self-evaluation by consumers: How would I rate my capacity in mobility or communication?

### At the institutional level

For educational and training purposes

For resource planning and development: What health care and other services will be needed?

For quality improvement: How well do we serve our clients? What basic indicators for quality assurance are valid and reliable?

For management and outcome evaluation: How useful are the services we are providing?

For managed care models of health care delivery: How cost-effective are the services we provide? How can the service be improved for better outcomes at a lower cost?

### At the social level

For eligibility criteria for state entitlements such as social security benefits, disability pensions, workers' compensation and insurance: Are the criteria for eligibility for disability benefits evidence based, appropriate to social goals and justifiable?

For social policy development, including legislative reviews, model legislation, regulations and guidelines, and definitions for anti-discrimination legislation: Will guaranteeing rights improve functioning at the societal level? Can we measure this improvement, and adjust our policy and law accordingly?

For needs assessments: What are the needs of persons with various levels of disability impairments, activity limitations and participation restrictions?

For environmental assessment for universal design, implementation of mandated accessibility, identification of environmental facilitators and barriers, and changes to social policy: How can we make the social and built environment more accessible for all persons, those with and those without disabilities? Can we assess and measure improvement?

# *The 'Flags Model*

The Three Flags are:

- Yellow flags are about the **Person** (thoughts, feelings, behaviours)
- Blue flags are about the **Workplace** (work and health concerns)
- Black flags are about the **Context** (relevant people, systems and policies).

Identification is about looking for unhelpful behaviours and circumstances. All players have a role in spotting flags related to:

- the **Person** with the problem;
- their **Workplace**;
- wider **Context** of their lives.

# *Roles*

## **Promote patients understanding of their condition**

### Role of Medical practitioners

- Communicate return to work options
- Provide sufficient consultation time
- Advise patients about the natural history of their condition
- Be aware that a patient's attitude to their injury or illness

# *Roles*

- **Employee and employer responsibilities to prevent disability**
  - Misunderstandings about work contribution ,to health conditions should be corrected.
  - Both employer and employee have roles and responsibilities that need to be assumed in this process.

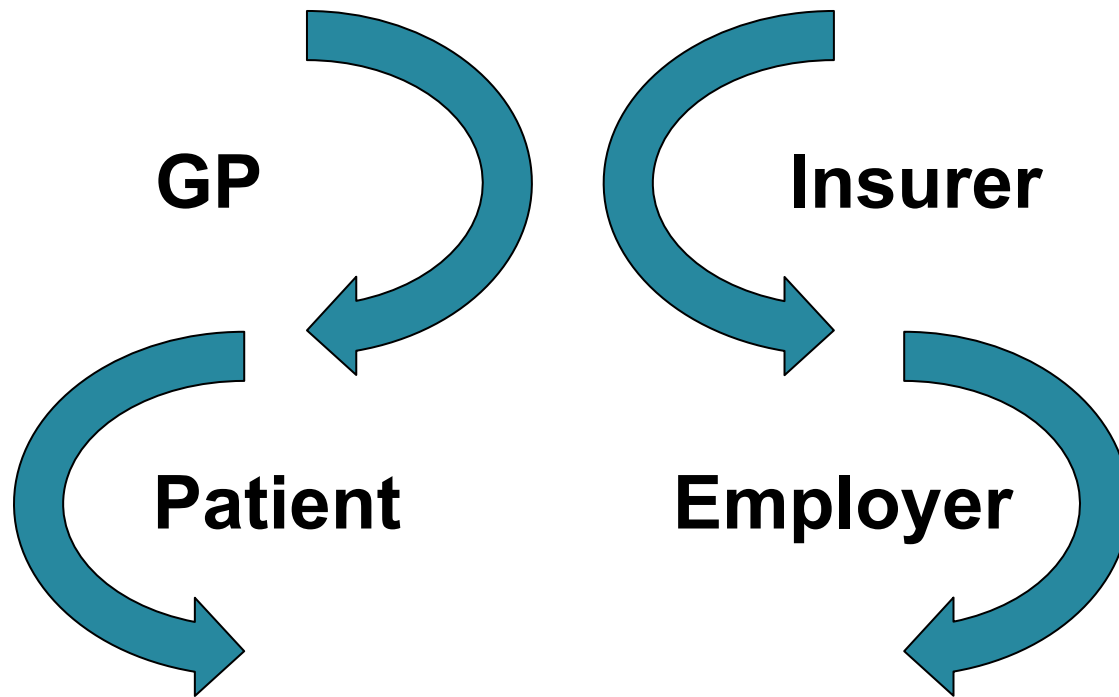
# *Roles*

## **Four major Principles for insurers to assist employers and employees:**

- To resolve claims justly and expeditiously
- To handle claims proactively to optimise the patients recovery time and process
- To act objectively and openly, with honesty and professionalism
- To keep patients and employers informed of the status and progress of their claims



# *Stakeholders relationships*



# *Circle of trust*

